

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

037734

3751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>St. Marys</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Inigoes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Inigoes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>		d. STREET ADDRESS <u>Rural</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Caroline</u> Last <u>Abell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1875</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard M. Abell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Sutton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Richard M. Smith - St. Inigoes, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary sclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arterio-sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>Mar 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 1, 1958</u> , and that death occurred at <u>7: A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>P.J. Bean, MD</u>		<u>3/3/58</u>	
PHYSICIAN'S NAME (Type) <u>P.J. Bean, MD</u>		<u>Great Mills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal</u>	22d. LOCATION (City, town, or county) (State) <u>St. Marys City, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Dee Smith</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]		NAME OF FUNERAL HOME [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]		NAME OF FUNERAL HOME [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	

BUREAU V. 2

MAR 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03735**

3752

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b X Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Leonardtwn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Hosp.			d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;">First ThomasMiddle AlbertLast Aud</div>			4. DATE OF DEATH <div style="display: flex; justify-content: space-between;">Month MarchDay 7Year 19 58</div>		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 21, 1935		9. AGE (In years last birthday) 23 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Clarence M. Aud		
14. MOTHER'S MAIDEN NAME Estelle Combs			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Clarence M. Aud - Great Mills, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;">PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Injury of Chest 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____</div>					INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lost control of auto & crashed into 3 other automobiles, going north on Rt. # 5		20c. TIME OF INJURY Month, Day, Year 9:45 1958			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Rt. #5			
20f. (City or town) Morganza, St. Marys, Md.		20g. (County) St. Marys			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE W. D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/7/58	
EXAMINER'S NAME (Type) W. D. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/58		22c. NAME OF CEMETERY OR CREMATORY Holy Face	
22d. LOCATION (City, town, or county) Great Mills, Md.		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.			24a. REC'D BY REGISTRAR DATE MAR 13 '58		
24b. REGISTRAR'S SIGNATURE W. D. Boyd			24c. (City or town) St. Marys		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 13 1958

BUREAU V. S.

DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3753

CERTIFICATE OF DEATH

Reg. Dist. No. 33736

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clements</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loveville,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>				d. STREET ADDRESS <u>Rural</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Alfred</u> Last <u>Bowles</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1866</u>		9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Bowles</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Graves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Fred Bowles - Loveville, Md.</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>332x</u> DUE TO <u>cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. p. <u> </u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>Jan 3, 1866</u> to <u>Mar 6, 1958</u> , that I last saw the deceased alive on <u>Mar 6, 1958</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Roy Guyther</u> M.D. <u>Mechanicsville, Md.</u>				DATE SIGNED <u>3/7/58</u>			
PHYSICIAN'S NAME (Type) <u>J. Roy Guyther, MD</u>				ADDRESS (Street, city or town, state) <u>Mechanicsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Morganza, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson, - Leonardtown, Md.</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u>MAR 13 1958</u> DATE <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. S.

MAR 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03737

3754

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN lb <u>Patuxent River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Marys Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Allie</u> Last <u>Caldwell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1918</u> 9. AGE (In years last birthday) <u>39</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supply Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Warehouse</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank B. Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>Nellie R. Furry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>US NAS</u>		16. SOCIAL SECURITY NO. <u>US NAS</u>	
17. INFORMANT <u>Frank B. Caldwell</u>		18. ADDRESS <u>Patuxent River, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull</u> DUE TO <u>823x</u> Conditions, if any, which gave rise to immediate cause (b) <u>5 hrs</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> DUE TO <u>5 hrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran off road while proceeding north on Route #5 & hit tree</u>	
20c. TIME OF INJURY Month, Day, Year <u>3-9-58</u> Hour <u>1:15</u> a. m. <u>pm</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STATE HIGHWAY</u>	20f. (City or town) <u>Park Hall</u> (County) <u>St Marys Md</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W.D. Boyd</u>		DATE SIGNED <u>3/9/58</u>	
EXAMINER'S NAME (Type) <u>William D Boyd, MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>3/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill, West Va.</u>	22d. LOCATION (City, town, or county) (State) <u>West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson</u> ADDRESS <u>Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 13 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Red Leach</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 13 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3755

CERTIFICATE OF DEATH

Reg. Dist. No. 03738

1. PLACE OF DEATH o. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Marys Hospital</u>				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>May</u> Last <u>Cox</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 27, 1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John W. Cornelius</u>				14. MOTHER'S MAIDEN NAME <u>? Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Margie Milstead - Leonardtown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma testes</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma left breast</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 8, 1957</u> , to <u>March 22, 1958</u> , that I last saw the deceased alive on <u>March 22, 1958</u> , and that death occurred at <u>2 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P.J. Bean</u> M.D.				ADDRESS (Street, city or town, state) <u>Great Mills, Md.</u>			
DATE SIGNED <u>3/23/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hamilton, Missouri</u>		22d. LOCATION (City, town, or county) (State) <u>Hamilton, Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Overman</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

227 1/2 1/2 1/2

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03739**

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drayden		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Eugene Last Dent				4. DATE OF DEATH Month March Day 2 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25. 1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	
10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Wilson Dent				14. MOTHER'S MAIDEN NAME Mary Q. Combs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-329145		17. INFORMANT Benjamin E. Dent		Address Drayden. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 20. min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 5:45 a.m. 3. 2. 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>William D. Boyd</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/2/58	
EXAMINER'S NAME (Type) William D. Boyd. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) 3201 Bladensburg Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE MAR 5 '58	
24b. REGISTRAR'S SIGNATURE <i>W. W. Chambers</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME SEX AGE RACE BIRTH PLACE OF BIRTH OCCUPATION RESIDENCE DATE OF DEATH TIME OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF EXAMINER COUNTY OF DEATH STATE OF DEATH		SEX AGE RACE BIRTH PLACE OF BIRTH OCCUPATION RESIDENCE DATE OF DEATH TIME OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF EXAMINER COUNTY OF DEATH STATE OF DEATH	
---	--	---	--

BUREAU V. S.

MAR 5 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3757

CERTIFICATE OF DEATH

Reg. Dist. No. 03740

1. PLACE OF DEATH a. COUNTY ST MARKS b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DRAYDEN RURAL c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY ST MARKS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DRAYDEN RURAL d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle O Last DENT		4. DATE OF DEATH Month MARCH Day 5 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1874
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY STORE KEEPER ST MARKS, CO. MD	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARTIN E. COMBS		14. MOTHER'S MAIDEN NAME SARAH FENHAGEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT BENJAMIN R DENT		Address DRAYDEN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDITIS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c) 10 years			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 , 1954, to Mch 5 , 1958, that I last saw the deceased alive on Mch 5 1958 and that death occurred at 10:53 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.H. Patrick		ADDRESS (Street, city or town, state) Lexington Park Md.	
PHYSICIAN'S NAME (Type) W.H. PATRICK M.D.		DATE SIGNED 3-5-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-6-58	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN	22d. LOCATION (City, town, or county) (State) BLADENSBURG MD
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO		ADDRESS 3072 MIST NUT	24a. REC'D BY REGISTRAR WASH, D.C.
		DATE MAR 7 '58	24b. REGISTRAR'S SIGNATURE W.W. Chambers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

MAR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3758

CERTIFICATE OF DEATH

Reg. Dist. No.

03741

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b X Leonardtown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCIS Middle Floyd Last Greenwell				4. DATE OF DEATH Month March Day 26 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1868		9. AGE (In years and birthday) 90 yrs.	IF UNDER 1 YEAR Months 1 Days 6	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William F. Greenwell				14. MOTHER'S MAIDEN NAME Sarah Matilda Floyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Cardiac failure. 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute Bronchial abd. DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Age 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that I attended the deceased from March 25 , 19 58 , to March 26 , 19 58 , that I last saw the deceased alive on March 26 , 19 58 , and that death occurred at 3 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles Greenwell M.D.				ADDRESS (Street, city or town, state) Leonardtwn Md.			
DATE SIGNED 							
PHYSICIAN'S NAME (Type) Charles Greenwell M.D. Leonardtwn, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/58		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Hollywood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCluskey Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE MAR 31 '58	
				24b. REGISTRAR'S SIGNATURE Al. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

MAR 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3759

CERTIFICATE OF DEATH

03742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Joseph Greenwell		4. DATE OF DEATH Month March Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1878
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 2 Days 15 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Spaulding Greenwell		14. MOTHER'S MAIDEN NAME Mary Ellen Spaulding	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-36-4496	
17. INFORMANT Grace E. Greenwell		Address Hollywood, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.02 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Serum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10 , 1958, to March 12 , 1958, that I last saw the deceased alive on March 12 , 1958, and that death occurred at 7 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles Greenwell M.D.		ADDRESS (Street, city or town, state) Leonardtwn DATE SIGNED 3/15/58	
PHYSICIAN'S NAME (Type) Charles Greenwell M.D.		Leonardtwn, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/15/58	22c. NAME OF CEMETERY OR CREMATORY St. John's	22d. LOCATION (City, town, or county) (State) Hollywood, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland	
24a. REC'D BY REGISTRAR MARY 4 58		24b. REGISTRAR'S SIGNATURE W. H. Houch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. B.

MAR 14 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3760

CERTIFICATE OF DEATH

Reg. Dist. No. 03743

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>Jerdon</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1958</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
10a. BIRTHPLACE (State or foreign country) <u>Ma ryland</u>		10b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. FATHER'S NAME <u>Thomas Jerdon</u>		12. MOTHER'S MAIDEN NAME <u>Agnes Bennett</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		14. SOCIAL SECURITY NO. <u>-----</u>	
15. INFORMANT <u>Thomas Jerdon - Lexington Park, Md.</u>		16. ADDRESS <u>Thomas Jerdon - Lexington Park, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 17, 1958</u> , to <u>Mar 18, 1958</u> , that I last saw the deceased alive on <u>Mar 18, 1958</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Patrich</u>		DATE SIGNED <u>Lexington Park Md. 3-18-58</u>	
PHYSICIAN'S NAME (Type) <u>William H. Patrich, MD</u>		<u>Lexington Park, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Great Mills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>		24a. REGISTERED BY REGISTRAR <u>Mar 25 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Patrich</u>		DATE <u>Mar 25 58</u>	

4200353XV3

BUREAU V. S.

MAR 26 1953

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3761

Reg. Dist. No. 03744

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood				c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Hollywood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Lathoun Last Lathoun				4. DATE OF DEATH Month March Day 10 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66		IF UNDER 24 HRS. Hours 66 Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Philip E. Clarke Address Hollywood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Wm D Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/58		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Hollywood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE MAR 11 '58	
						24b. REGISTRAR'S SIGNATURE Overland	

BUREAU V. S.

11 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 ²

3762

CERTIFICATE OF DEATH

Reg. Dist. No. 03745

1. PLACE OF DEATH o. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New York</u> b. COUNTY <u>Queens</u> <u>Maryland</u> <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u>		c. LENGTH OF STAY IN 1b <u>24 Minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Station Hospital USNAS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bernadette</u> (N) <u>LENNON</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 March 1958</u>
9. AGE (In years lost birthday) yrs. <u>24</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Owen Thomas LENNON</u>	
14. MOTHER'S MAIDEN NAME <u>Patricia Ann TAIT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Official US Navy Records.</u> <u>USNAS Patuxent River, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 Min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>31 March</u> , 19 <u>58</u> , to <u>31 March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>31 March</u> , 19 <u>58</u> , and that death occurred at <u>4:44 P.M.</u> , from the causes and on the date stated above. <u>P. TO Regan</u> ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4-1-58</u> ACTUAL SIGNATURE <u>P.T. O'PEGAN, LT MC USNR</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>P.T. O'PEGAN, LT MC USNR</u> <u>Station Hospital USNAS Patuxent River, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Great Mills, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Station Hospital, USNAS, Patuxent River, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>			

31

BUREAU V. B.

APR 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03747

3763

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Clements			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Darlene Middle Queen Last Queen				4. DATE OF DEATH Month March Day 24 Year 1958			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1957	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 22		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Bowman				14. MOTHER'S MAIDEN NAME Genevieve Queen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Genevieve Queen Clements, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Bronchitis pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) — (c), stating the underlying cause last. DUE TO —							
INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. —				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W.D. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William D. Boyd M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/58		22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE MAR 27 '58		24b. REGISTRAR'S SIGNATURE —	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1959

RECEIVED

3764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 5 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Bernard Last Thompson		4. DATE OF DEATH Month March Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 1 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Aloysius Thompson		14. MOTHER'S MAIDEN NAME Cora Latham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Teresa Mary Thompson		Address Rt.1 Lexington Pk.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month Day Year 19 Hour a. m. p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/5 , 19 58 , to 2/5 , 19 58 , that I last saw the deceased alive on 2/5 , 19 58 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 317 Great Mills Rd. Lexington Park, Md. DATE SIGNED 			
ACTUAL SIGNATURE Julian S. Lane		M.D. 317 Great Mills Rd. Lexington Park, Md.	
PHYSICIAN'S NAME (Type) Julian S. Lane MD		Lexington Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/8/58	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	22d. LOCATION (City, town, or county) (State) Bushwood, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR DATE MAR 10 '58		24b. REGISTRAR'S SIGNATURE W. Clarke	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH BALTIMORE		STATE MARYLAND	
DATE OF DEATH MAY 10 1958		TIME OF DEATH 10:00 AM	
DECEASED JOHN H. HARRIS		AGE 65	
SEX MALE		RACE WHITE	
EDUCATION HIGH SCHOOL		OCCUPATION LABORER	
MARRIAGE MARRIED		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
SIGNS AND SYMPTOMS PAIN IN CHEST, SHORTNESS OF BREATH, SWEATING		TREATMENT MEDICAL	
HISTORY DECEASED WAS IN GOOD HEALTH PRIOR TO DEATH		FAMILY HISTORY FATHER: HEART DISEASE, MOTHER: HYPERTENSION	
SOCIAL HISTORY DECEASED WAS A NON-SMOKER AND DRANK MODERATELY		HABITS NON-SMOKER, MODERATE ALCOHOL CONSUMPTION	
DIET DIET WAS USUALLY GOOD		EXERCISE DECEASED WAS A REGULAR WALKER	
MEDICATION DECEASED WAS TAKING ASPIRIN AND NITRATES		ALLERGIES NO KNOWN ALLERGIES	
FAMILY DECEASED WAS MARRIED AND HAD TWO CHILDREN		BURYAL DECEASED WAS BURIED IN BALTIMORE	
SIGNATURE OF PHYSICIAN JOHN H. HARRIS		SIGNATURE OF REGISTRAR JOHN H. HARRIS	
DATE MAY 10 1958		PLACE BALTIMORE	

RECEIVED
MAR 10 1958
BUREAU V. S.